ARIZONA DEPARTMENT OF HEALTH SERVICES
DIVISION OF LICENSING SERVICES-OFFICE OF LONG TERM CARE LICENSING
150 North 18th Avenue, Suite 440 $ Phoenix, Arizona 85007
400 West Congress Avenue $Tucson, Arizona 85701

INITIAL APPLICATION FOR A HEALTH CARE INSTITUTION LICENSE

A.R.S. Title 36, Chapter 4 and A.A.C. Title 9

I. HEALTH CARE INSTITUTION INFORMATION

DHS use only-Facility ID	_____ CHOW_____INITIAL	Application #
Name of health care institution		
Street address		
City	Zip code	Phone number
Tax I.D. number	Fax number	E-mail address
Mailing address		
City	State	Zip code
Requested health care institution class or subclass:(listed in R9-10-102)		
Requested licensed capacity:		

A. Is the proposed health care institution (except for a home health agency or a hospice service agency) located within 1/4 mile of agricultural land?
____Yes ____ No If yes:
1. Include on a separate sheet of paper the names and addresses of owners or lessees of any agricultural land within 1/4 mile of the proposed health care institution, and
2. Attach a copy of the written agreement between the health care institution owner and the owner or lessee of agricultural land prescribed in A.R.S. ' 36-421(D).

B. Is the proposed health care institution located in a leased facility?
____Yes ____ No If yes, attach a copy of the lease showing rights and responsibilities of the parties.

C. If a proposed health care institution is not exempt from submitting architectural plans and specifications pursuant to A.R.S. ' 36-422(E) attach one of the following:
1. A copy of DHS approval of the proposed health care institution=s architectural plans and specifications, or
2. The architectural plans and specifications for the proposed health care institution required in A.A.C. R9-10-105(A)(5)(a).

D. Is the proposed health care institution ready for an inspection by Department representatives?
_____Yes ____ No If no, date the proposed health care institution will be ready

II. OWNER INFORMATION

Owner=s name		
Address		
City		Zip code
Telephone number		Fax number
The owner is a (check one) :	_____Proprietary	_____Non-proprietary
The owner is a: (check one)	_____Sole proprietorship	_____Partnership
_____Limited liability company	_____Corporation	_____Governmental Agency

A. PLEASE LIST IN THE SPACE PROVIDED BELOW:

If the owner is a partnership, the name of each partner;
If the owner is a limited liability company, the name of the designated manager, or if no manager is designated, the names of any 2 members of the limited liability company;
If the owner is a corporation, the name and title of each corporate officer; or
If the owner is a governmental agency, the name and title of the individual in charge of the governmental agency or the individual designated in writing by the individual in charge of the governmental agency.

Name	Title
Name	Title
Name	Title
Name	Title

B. If applicable, attach a copy of the articles of incorporation, the partnership documents, or the limited liability company documents.

C. Has the person applying for a license or a person with 10% or more business interest in the health care institution had a health care professional license or certificate denied, revoked or suspended?
____Yes ____ No

D. Has the person applying for a license or a person with 10% or more business interest in the health care institution had a license to operate a health care institution denied, revoked or suspended?
____Yes ____ No

E. If either of the above questions is answered yes, include on a separate sheet of paper for each yes answer:
1. The reason for the denial, suspension, or revocation;
2. The date of the denial, suspension, or revocation;
3. The name and address of the licensing agency that denied, suspended, or revoked the license.

Statutory agent (or individual designated to accept service of process and subpoenas)

Name	Title
Address	Telephone number

III. GOVERNING AUTHORITY

Name

IV. CHIEF ADMINISTRATIVE OFFICER

Name	Title
Education (list the highest educational degree obtained and any instruction related to the health care institution class or subclass for which licensure is requested)	
Experience (list work experience related to the health care institution class or subclass for which licensure is requested)	

V. SIGNATURES

According to A.R.S. ' 36-422(B) an application must be signed, as follows:

(1) If an individual, by the owner of the institution;

(2) If a partnership or corporation, by two of the partners or corporate officers; or

(3) If a governmental unit, the head of the governmental department having jurisdiction.

A.A.C. R9-10-105(A) requires the application signatures to be notarized.

_____	_____
Signature Date	Signature Date
_____	_____
Title	Title
STATE OF_____)	STATE OF_____)
COUNTY OF _____)	COUNTY OF _____)
Subscribed and sworn to before me this	Subscribed and sworn to before me this
_____ day of _____,	_____ day of _____,
by	by
Notary Public	Notary Public
My Commission Expires	My Commission Expires

Attach:

1. Documentation from the local jurisdiction of compliance with all applicable local building codes and ordinances.
2. If accredited by a nationally recognized health care accreditation agency, a copy of the current accreditation.

VI. TIME FRAME

Pursuant to A.R.S 41-1075 the applicant agrees to extend the substantive review time frame and overall time frame if necessary. This will not exceed 25% of the overall time frame.

Provider Signature:_____ ***Representative of DHS:_____***

For DHS use only: Correct application fee enclosed: _____ Yes _____ No Check #:_____

APPLICATION SUPPLEMENT

Long Term Care

NAME OF INSTITUTION:_____

I. Does this facility provide:

_____ A secured area for residents with Alzheimer's disease or other dementia?

_____ A secured behavorial health services area?

_____ An area for residents on ventilators?

II. Name and license classification of institution(s) operated in conjunction with the nursing care institution:

_____

_____

_____

_____

Signature of Administrator

_____

Signature Date

Division of Assurance and Licensure Services
Office of Long Term Care Licensure
150 North 18th Avenue, Suite 440
Phoenix, Arizona 85007
(602) 364-2690 (602) 364-4765 FAX

APPLICATION AND LICENSE FEE REMITTANCE FORM

PLEASE RETURN THIS FORM WITH THE PAYMENT TO THE ADDRESS ABOVE

Application Fee $50.00

License Fees, based on licensed capacity, are as follows:

- For a facility with a licensed capacity of one to fifty-nine beds, one hundred dollars plus an additional fee in the amount of the licensed capacity times ten dollars.
- For a facility with a licensed capacity of sixty to ninety-nine beds, two hundred dollars plus an additional fee in the amount of the licensed capacity times ten dollars.
- For a facility with a licensed capacity of one hundred to one hundred forty-nine beds, three hundred dollars plus an additional fee in the amount of the licensed capacity times ten dollars.
- For a facility with a licensed capacity of one hundred fifty beds or more, five hundred dollars plus an additional fee in the amount of the licensed capacity times ten dollars.

FEES				**AMOUNT DUE**
Application Fee (Please do not submit the application fee if the fee has already been paid.)				$ 50.00
LICENSED CAPACITY				
Check One:	Licensed Capacity:	Base Fee:	Number of Beds x $10.00 each:	Total base fee plus number of beds fee:
	1 to 59 beds	100.00		
	60 to 99 beds	200.00		
	100 to 149 beds	300.00		
	150 or more beds	500.00		
TOTAL AMOUNT DUE				$

Payment should be by cashier's check, money order or business check made payable to:
ARIZONA DEPARTMENT OF HEALTH SERVICES

Write the Facility I.D. # on the check.
Cash and personal checks are not accepted.

AMOUNT ENCLOSED	$

ALL FEES ARE NON-REFUNDABLE pursuant to A.R.S. § 36-405(c), 36-882(f) and 36-897.01(c), except as provided in A.R.S. § 41-1077.